DEPARTMENT OF ENVIRONMENTAL QUALITY
OFFICE OF ENVIRONMENTAL COMPLIANCE
EMERGENCY & RADIOLOGICAL SERVICES DIVISION
LICENSING & REGISTRATIONS SECTION
POST OFFICE BOX 4312
BATON ROUGE, LOUISIANA 70821-4312
PHONE: (225) 219-3041 FAX: (225) 219-3154

Office Use Only
APPLICATION
AI#
Registration No.
Docket No.

APPLICATION FOR REGISTRATION OF RADIATION SOURCE

DRC-6 (6/06)

Must check all that apply:

New Registration
Change of Address or other Information (see pg 2)
Shielding Evaluation Information (see pg 2)
Disposition of Equipment, ie. required information if this unit replaces an existing one (See pg 3)

FACILITY INFORMATION

1. Company Name/Facility Name

2. Name of Owner

3. Mailing Address: No. & Street City & State Zip Code Parish

4. Billing Address: No. & Street City & State Zip Code Parish

5. Address at which x-ray unit will be used

6. Area Code-Telephone Number of Facility

7. Room No. & Location where source will be used

8. Type of Facility

Hospital (IM) | Medical Clinic (PM) | Private Medical Practice (PM) | Educational Institution (ED)
Industrial (IN) | Industrial Radiography (IR) | Private Dental Practice (PD) | Other (Specify):_____
Veterinary (VT) | Chiropractic (DC) | Dental Clinic (PD)

USER INFORMATION

9. Individual in Charge of Source (RSO, operator, etc.)

10. Individual Responsible for Radiation Protection

11. Classification of Individual in Charge of Source

Dentist | General Practitioner | Health Physicist | Registered X-Ray Technologist
Radiologist | Industrial Radiographer | Veterinarian | Non-Registered X-Ray Tech.
Chiropractor | Podiatrist | Osteopath | Other (Specify):_____

SOURCE INFORMATION

12. Source

A. Medical X-Ray
Fluoroscopic w/ Image Intensifier
Fluoroscopic w/o Image Intensifier
Combination *w/ Image Intensifier
Combination *w/o Image Intensifier
Radiographic
Photofluorographic
Mammography
CT
*Radiographic & Fluoroscopic Combination

Bone Densitometer
Deep Therapy
Superficial Therapy
Special Procedures

B. Dental X-Ray
Conventional
Panoramic
Cephalometric

C. Accelerator:
Neutron Generator
Van de Graaff
Linear Accelerator

D. Other X-Ray
Industrial Radiography
Diffraction Apparatus
Cabinet
Other (Specify)_____

Date Installed: _____

Replacing Old Machine (See page 3)
Yes
Old Registration #: _____
No

13. Source is: Fixed Mobile

14. **Control Panel Information (Use one form for each panel):** *Use only information from Control Panel*

a. Manufacturer	b. Model Number	c. Serial Number	d. Number of Tube Heads	e. Max. kVp	f. Max. mA

CERTIFICATION

15. This is to certify that, to the best of my knowledge and belief, all information contained herein, including any supplements attached hereto, is true and correct.

_____ _____ _____ _____
Date | Primary Contact Person (Print) | Applicant (Print) | Signature of Responsible Party

Submit the completed original application for each x-ray unit to the above address, and maintain a copy for your files.

NOTE: All applications must be signed and dated before a Registration Certificate can be issued.

Shielding Evaluation Information: *If shielding is required for X-ray unit and has already been approved by the Department please attach a copy of the approval letter. If letter is not available, submit the following information:*

Room Housing Unit (Description or Room Number):	Date of the Department approved shielding:	Shielding review form enclosed Shielding review form recently submitted and waiting for approval

Transfer Information: *If facility/machines were transferred from a different location, please provide the following information for the previous location.*

FACILITY INFORMATION

1. Company Name/Facility Name		2. Name of Owner	
3. Mailing Address: No. & Street	City & State	Zip Code	Parish
4. Billing Address: No. & Street	City & State	Zip Code	Parish

5. Address at which x-ray unit will be used	6. Area Code-Telephone Number of Facility	7. Date of Transfer

Please provide any other detailed information that will assist the department in registering your machine(s).

_____

_____

_____

_____

RADIATION MACHINE DISPOSITION FORM

TO AVOID PAYING A FEE ON A RADIATION MACHINE THAT IS NO LONGER IN YOUR POSSESSION OR INOPERABLE IN THE MANNER DESCRIBED BELOW, THE FOLLOWING REQUESTED INFORMATION **MUST BE RECEIVED BY THE DEPARTMENT BY THE INVOICE DUE DATE.**

Registration No. of radiation machine no longer in your possession or deemed inoperable: _____

Manufacturer of above machine: _____ Serial number of above machine: _____

If machine was transferred, list person/company and address that machine was transferred to:

_____

_____

_____

Indicate if machine is "Inoperable" in the manner listed below: _____

A machine is inoperable only if the machine's X-ray tube (insert) has been removed in such a manner that it would require an X-ray company/service person to make it operable. With the X-ray tube in place, the unit is considered to be operable.

If you have any questions, please contact the Department at (225) 219-3041.

_____ AGENCY INTEREST ID (if known)

_____ NAME OF APPLICANT

_____ DATE